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Treating the Person with a Gambling Problem

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Abstract

This short article presents compelling reasons for the treatment of problematic gambling from a solution-focused brief therapy (SFBT) perspective. It reviews a set of techniques designed for use by practitioners and clients who face this problem

and its serious emotional, social and financial consequences. Although SFBT has theoretical and philosophical foundations, the focus of this article is the “how-to” aspect of importance to both clinicians and clients. SFBT lends itself well to self-help models and group therapy settings, since clients can benefit from asking similar questions of themselves or of one another in group settings.

Why SFBT Is Useful to Clinicians

Factory Worker Hits the Big One! Super Jackpot Now Worth $142,000,000! These stories make glamorous headlines for local papers. However, reading such stories pales in comparison to the excitement when faced with all the bells and whistles and glorious possibilities upon entering a casino, or the adrenaline of anticipation when buying bands of lottery tickets. Even these experiences pale in comparison to hearing the jingle of apparent winnings, which in turn can only be a fraction of what it must feel like to win big! On a scale of 1 to 10, if the excitement of reading thes success stories is a 1, then hitting it big must be 115!

Stories of personal destruction, which are at least as common as tales of big winnings, seem to get lost in the back pages. There is no vicarious excitement or adrenaline rush associated with reading about “Family Sells House to Pay Gambling Debt” or “Suicide the Cost of Man's Shame Over Gambling Debts.” But if you are taking the time to read this article, you already know that gambling can be a serious problem. Perhaps the more relevant and important question, then, is “What are the solutions?”

It is reasonable to expect that a problem as persistent and serious as gambling, with its insidious effects on every aspect of a problem gambler's life, would take a long time and lots of money and energy to solve. Yet, our experiences have shown us that problematic gambling is not a uniform entity with a predictable course of treatment and outcome, but comes with complex, multi-faceted symptoms that make it difficult to foretell what might be the problem and the appropriate treatment. We are confident in asserting, however, that most clients' life goals are similar to those of the rest of the population. That is, they want to be competent in what they do, earn a living, raise a family and feel productive in their endeavors; they also want to feel respected for their abilities and accepted and loved for who they are. These are modest and realistic goals but they may be difficult to achieve for those with serious problems.

As will be described more in detail later, rather than “dis-solving” problems, building solutions focuses on a desirable future state of being rather than understanding what went wrong. Thus, it builds on strengths, rather than shoring up personal deficits. It is a time-sensitive, cost-effective approach that meets relevant criteria for efficient, effective and collaborative ways of working with clients.

Problem-Solving and Solution-Building Approaches

The most widely accepted perspective in the field of mental health, addiction and other human services is based on the “scientific,” or medical, model. Described as a “problem-solving” approach (DeJong & Berg, 2001), this model begins with a detailed description of the problem, based on the belief that there is a causal relationship between problems and solutions.

This is typically carried out by (1) obtaining detailed information about the origin of the problems and description of symptoms to understand the nature of the problems. The next step (2) is to assess what category the problem falls in; for example, whether it fits the mental health description of depression or compulsive behavior, or whether the origins have a genetic basis. The third step, (3) is to find the solution that matches the problem, followed by the fourth step (4) of a prescription for the appropriate remedy. It is easy to see that this problem-solving model is reasonable and sensible in many ways since we all want to know the causal relationship between problems and solutions. It is easy to recognize that this approach is heavily dependent on the expert knowledge of the professional who diagnoses the problem, makes the connection between problem and solution, prescribes the remedy and then follows up with an evaluation of whether the remedy was carried out and whether it worked.

When the nature of the problem is physical or medical, this kind of mechanistic approach makes sense and has yielded an amazing array of new remedies once thought impossible in medicine and science. However, what clients bring to the mental health or addiction treatment field is much more complex than treating physical problems where one can see the broken bones or identify the bacterium that causes fever. People, unlike germs, attach meaning to their illness, their misery or undesirable behaviors, all based on their unique personal experiences and history. This distinctive human activity of attaching meaning to events and wanting to understand what is behind them is both normal and highly individual.

The solution-building approach, in contrast, begins with eliciting clients' views of what would be a better life. By seeking professional help, clients acknowledge that their current state of affairs is unsatisfactory or unacceptable on a personal level or to the people around them, or both. Therefore, beginning with a client's views and criteria for what is a desirable state of being, therapists set the stage for goal negotiation (which is addressed later). Once the goal is negotiated, the next step is to learn about the client's frame of reference; that is, what is this person's unique way of orienting himself or herself in this world? For example, does this person view the world as hostile or friendly? Does the person view the problem as solvable, or hopeless and beyond solution? A host of other information can guide us toward understanding what might be a useful way to work with this client.

The third step is to discover the client's ability to find solutions; that is, the client's experience of exceptions to problems. For example, times when he or she could have gambled but somehow managed to stay away from it. These exceptions become the building blocks for tailoring solutions to fit a particular client. As treatment progresses, clients are asked to assess their own progress until they feel confident to carry out daily tasks in a manner they consider satisfactory.

The solution-building process is driven by the client's view of his or her daily life in the real world outside of the therapy room. This approach further assumes that clients not only have ideas about what is good for them but also possess the beginning to their solutions, which is significant, however small. It becomes apparent why client resistance is at a minimum, thus treatment moves along rather quickly and without the need to confront denial.

We contend that these are compelling reasons for clinicians to adopt this solution-building stance. Therapists using this approach (1) employ goal-driven activities negotiated with the client; (2) recognize that only the client can change (since we follow what the client is interested in changing); (3) are highly respectful of clients' own expertise in their own life circumstances based on personal history and life experiences; and (4) build on resources already existing in the client's life, rather than filling in or eliminating deficits. When this non-pathological approach is used, (5) the treatment becomes short-term and long-lasting because we are working with the client's resources, not her or his deficits.

More detailed descriptions of the underlying assumptions and clinical postures are described and explained by writers who have worked with a wide variety of client populations from many cultural backgrounds in many settings (de Shazer, 1985, 1988, 1994; Berg & Miller, 1992; Dolan, 1992; Berg & de Shazer, 1993; Berg & DeJong, 1996; Berg & Reuss, 1997; DeJong & Berg, 1998; Berg & Kelly, 2000; Berg & Dolan, 2001; Berg & Steiner, 2002). Now we will make a more detailed description of the useful techniques that form the foundation of SFBT.

Goal Construction and Negotiation

The beginning point for working with problematic gambling (or any other presenting problem) is a goal — not just any goal, but the client's goal(s). This is a particularly important emphasis, especially in relation to such a personally value-laden topic as gambling. Therefore, a session might begin with the therapist asking the client, “So, what needs to come out of our meeting today that will let you know it was useful and helpful?” This beginning immediately sets the tone for the client by stressing that the therapist is interested in learning what she or he wants from the session and that something positive might come out of even this one meeting. This orients clients toward a positive outcome and an expectation that there will be an

end to their problems and suffering.

It is easy to assume that all clients know specifically what they want. Our experience, however, tells us that most people think of goals in vague terms and as the absolute absence of the problem. Most clients say, “I'm so tired of being in debt, being scolded or sneaking around that I just want this monkey off my back.” While such desires are perfectly understandable, constructing a workable goal requires more precise definition of the beginning of a successful outcome, as the following dialogue indicates.

> **Client (C):** I am so sick of being broke, feeling guilty all the time, sneaking around.
>
> **Therapist (T):** I can imagine you are tired of living this way. So, what would you like to see yourself doing instead?
>
> **C:** I don't know … I just want to be at peace with myself and my family.
>
> **T:** Good idea, and it sounds like you could use some of that. So, what would you do when you get this peace that you are not doing right now?

The goal of treatment should be stated as a presence of something, not the absence of the problem. That is, what will the client do with his or her time, energy, money, and so on, when no longer gambling? The goals must be concrete, measurable, behavioral and countable; an operational definition. In other words, goals must be constructed in a fashion that creates an opportunity for clients to recognize the signs that they are moving toward successful mastery over their problem. The goal must point to the beginning of a solution rather than the ending of a problem; it must be realistic and congruent with the client's lifestyle and social context.

For example, a large proportion of the initial meeting can be devoted to turning vague goals into something that is measurable so that the client can recognize the beginning of successful steps toward her or his goals. For instance, consider the following, common dialogue:

> **C:** I just want to understand why I have this problem, why do I keep doing things that are personally destructive. I feel like such a hopeless case. Why am I doing this to myself?
>
> **T:** Of course, it makes sense that you would ask that. So, suppose you somehow come to understand why you keep doing things that are destructive to you, what will you do then that you are not doing right now?

C: I don't know, but at least I'll feel like a normal person, like everybody else, spend more time with my family, do what most people do. You know, like going out to eat, going to a movie, taking my kids to a park, going for a walk, stuff like that will make me feel normal like everybody else.

T: So, what you really want is to be normal, do normal things that other people do and feel good about doing those things.

C: Yeah, I haven't felt like that for such a long time, it seems.

In addition to respecting the client's desire to be “normal,” which clearly needs further clarification in operational terms, feeling and doing “normal” things is much easier to conceptualize because “being normal” has a much longer list of activities and wider choices than “kicking the gambling habit.” We want clients to find ways to feel successful immediately so that they begin to be hopeful about themselves, perhaps even as early as tomorrow morning. We also like to emphasize that the client's goal must be described in terms of his or her social context and significant social relationships because of the very nature of destructive influences on the people around the gambler. Therefore, further negotiation of goals might go like this:

T: So, suppose you are calmer, can hold your head up high, spend more time with your family and help your children with homework and these things you've been talking about. What would be different between you and your wife (children, best friends, employer, etc.)?

C: That'd be so good; we would get along, talk more, have dinner together now and then, spend more time around the house with each other. We avoid each other right now, and we hardly talk anymore, except for “Who is taking the kids to school?” and stuff like that.

At every step of the way, the clearly articulated client goal takes the center stage in subsequent contacts and becomes the guidepost for successful treatment. We believe it is important to know when to stop treatment even as the relationship begins.

Even when the client comes to treatment under coercion, or outside pressure from a spouse, court or employer, and is seemingly unmotivated, the following dialogue shows how the therapist can find out what and who is important to the client. The approach is founded on basic respect for client competence and the belief that clients know what is good for them. We believe the client's ideas should take priority over our “expert” knowledge, since it is the client who must actually implement the necessary changes. This is illustrated in the following dialogue

where a client comes to see a therapist under duress.

> **T:** What would you like to accomplish as a result of coming to see me? How can I be most helpful to you today?
>
> **C:** I don't know. My wife wanted me to come and see you. She thinks I have a problem.
>
> **T:** Oh, I see, and she wants you to do something about this problem she thinks you have?
>
> **C:** Yes.
>
> **T:** So you must agree with her, or at least want to get along with her in order for you to follow through with her request.
>
> **C:** Well, I don't know if I agree that it's a problem. But I do care about her enough to at least come here and talk to you about it.
>
> **T:** I can see that you are respectful of her ideas. Would it be helpful for me to know what this problem is that your wife wants you to change?
>
> **C:** Well, she thinks I gamble too much.
>
> **T:** I see. How is this a problem for you, her thinking that you gamble too much?
>
> **C:** Well, I don't want to fight with her all the time and she has even threatened to walk out on me and I really don't want that. I love her and we've been together for over 10 years and we've got two kids.

As you can see from this example, the client's goal shifts rather quickly from “my wife wants me to come and see you” to “I don't want to fight with her all the time,” to “I love her,” and the desire to keep the marriage. The client was not able to articulate this when he first walked into the meeting with the therapist, but by the end, things have become clearer to both the client and the therapist. Keeping the marriage together and not fighting with his spouse, along with letting her know he loves her is what is important and meaningful to the client. These could easily become the primary motivating factors for the client.

Negotiating Goals When There Are Multiple Problems

Rather than assuming that a consuming, overwhelming and out of control problem such as gambling must stop before other problems can be solved, we ask the client which problems need to be addressed first to feel like he or she is taking the

beginning step. Clients often come up with concrete steps that give them feelings of hope to move forward, instead of leaving them overwhelmed and paralyzed. These steps may be quite contrary to what the therapist believes should be the first step. Before the next dialogue, Mr. Taylor (a pseudonym) presented a long list of problems that he was facing: possible job loss, separation from his wife and possible divorce, foreclosure of his house, the inability to afford the uniforms and travel costs for his children to join a baseball team. Of course, he was depressed and felt discouraged; his drinking problem had become so serious that he was increasingly absent from his job. When we asked Mr. Taylor which problem he needed to solve first to feel like there was some light at the end of the tunnel, without hesitation he responded that he needed to start jogging first. Surprised at this answer, the therapist asked him further about his ideas on how jogging would be helpful, “Explain to me again, what difference would it make for you?” He described how whenever he stopped jogging, his whole outlook on life changed. Further exploration of this idea produced the information that whenever he felt physically fit, he started to take care of himself better, he reduced his drinking considerably and ate healthier, he felt more productive, his depression lifted and he was more focused on his goals, and his gambling was also under better control.

Again, we contend that when we therapists engage clients in useful conversations to recognize that every problem has an ebb and flow, then we are more likely to listen for the client's solutions. Clinicians can follow through with questions that elicit information about who in the client's social environment will support and encourage such positive behaviors and how. The following questions produced useful information about Mr. Taylor's support from those significant others.

> **T:** So, suppose you start jogging, say, tomorrow morning, what would your family say that tells them this is helpful for you?
>
> **C:** My wife would say that I am calmer, easier to be around, and the children like it because I pay them more attention.
>
> **T:** So, when she notices that you are calmer, what does she do that is helpful to you?
>
> **C:** I can tell it helps her also because she herself is calmer and easier to talk to.
>
> **T:** So, what else is different around the house when you are jogging regularly?
>
> **C:** You know, I never thought about it but I would have to say that the children are calmer, also, and they want to be around me more, instead of avoiding me and being cranky and irritable. Boy, I never realized how

much influence I have on them.

T: So, what do you need to do first? (Or what would your family say that you need to do first?)

Since the idea of getting started on jogging was initiated by Mr. Taylor, he is much more likely to invest in carrying out his own idea. You can see the ripple effect that he can create simply by getting up and jogging; not only for himself but also his entire family, and perhaps, his marriage.

Exceptions to Problems

As the client's goal(s) becomes well defined, another area of emphasis to focus on is exceptions to the problem. We have observed uncountable examples wherein workable goals or solutions were evident even before the client entered treatment. Contrary to the common language usage that implies that problems exist all the time (e.g., He's an alcoholic; she's lost control over her gambling problem; he's depressed all the time), we contend that all problems have exceptions. That is, times when a client could have gambled, but somehow managed to stay away from buying lottery tickets. For instance, perhaps the person deliberately went to a gas station that does not sell them.

Consistent with our respect for client competence, we are more interested in learning about the client's own expertise about the absence of the problem than promoting our own “expertise” about eliminating or avoiding the problem. Accordingly, we spend considerable time and energy exploring exceptions to the problem in detail.

In problematic gambling, as in most other problems of impulse control, we find that these exceptions are bountiful. The following are some of the examples of questions that help us learn about exceptions:

- Tell me about the times when you have experienced reaching this goal you've been talking about, even a little bit.
- Tell me about the times when you don't feel the urge to gamble.
- What is different about those times?
- When you are not gambling, or don't want to gamble, what are you doing instead?
- What do you suppose your family (spouse, children, etc.) would say they like the best about you when you are not thinking about gambling?
- What do you suppose they see as different about you during those times?
- When you are more loving and a good parent, one your children would want to continue in a relationship with, what are you doing differently?

We are highly interested in *different* and *instead* questions. Answers to questions about *exceptions, differences* and *instead* provide us with the stepping stones to solutions. Accordingly, such questions of *difference* and *instead* open doors to other resources that a client may have forgotten about.

Exceptions point toward solutions; that is, exceptions indicate what the client is capable of doing, thus highlighting successes and suggesting what the client needs to do more of. Because these exceptions are self-generated and come from the client's own social and environmental contexts, these small successes are easier to repeat and amplify once they have been identified.

Scaling Questions

Another useful tool in this approach is the use of scaling questions. It seems that impulses to measure, count, compare before and after, compete with oneself as well as with our neighbors, and so on, are universal. Consequently, everyone who understands the numbers 1 to 10 can respond to and benefit from scaling questions.

Language and conversation are the only true tools of therapy, which is both good and bad. We can often run into difficulties because language can be vague and uncertain. At other times, language forces us into dichotomies such as black or white; trustworthy or untrustworthy; honest or dishonest, and so on, in which we must take a position. Since language is the most common tool we have to describe and create reality, this can be limiting and liberating at the same time. In an attempt to reduce some of the ambiguities of language, we substitute numbers for concepts and constructs to make them more precise. In other words, we “make numbers talk” (Berg & de Shazer, 1993). Doing this helps clients to assess their own situation and determine what steps they need to get to the next level of achievement and success.

Described as “self-anchored measurement,” numbers on scales move up and down; thus, this form of conversation is more flexible than the language we commonly use. Using numbers in a scaling fashion also assists in breaking down the erroneous perceptions of false dichotomies that many clients and professions endorse: problems vs. no problem, confidence vs. no confidence, motivated or unmotivated, and so on.

Beginning practitioners can easily misunderstand scaling questions to be assessment questions, as if the scale of 1 to 10 is based on normative standards, where the answer 7 represents something objective or has some analytical meaning. “Unlike scales that are used to measure something based on normative standards (i.e. scales that measure and compare the client's functioning with that

of the general population along a bell curve), the scales we use are designed to facilitate treatment. Our scales are used to 'measure' the client's own perception, to motivate and encourage and to elucidate the goals and anything else that is important to the individual client" (Berg & de Shazer, 1993, p. 10). Here are some examples:

> **T:** OK, on a scale of 1 to 10, where 1 is your gambling when at it's worst and 10 stands for when the problem is gone, where would you say you are at today?
>
> **C:** I don't know. I haven't been gambling for the past two weeks, but I'd say I'm only at 3 or 4.
>
> **T:** A 4?! Already? This is good! How did you do that?
>
> **C:** Well, I decided that it was getting out of hand and that it won't kill me if I just stay away from there for two weeks and really test if I can do it or not. Actually, it's not been that bad. I try to distract myself, I think about something else, like how much the apartment needs fixing, how I've neglected my exercise, haven't called my mother for almost a month, so I just picked up the phone and called her.
>
> **T:** It sounds like you've got a great start going. What do you suppose will be different as you maintain this 4 and maybe even start moving toward a 5?

Scales can be used to measure confidence, progress toward client's goals, instill hopefulness and motivation to make life better, and a host of other intangible elements too vague to describe, thus creating incremental, small steps toward the client's goals. Further elaboration of a client's personal meanings attached to certain numbers can be made in the following ways:

- What tells you that you are at 4?
- How is your life different at 4 compared to when you were at, say, 1 or 2?
- How long have you been at 4?
- What would you say your partner (best friend, employer) likes about your being at 4?
- You have had many ups and downs with your gambling over the years. How confidently would your family say that they believe you will maintain 4 and move up to 4.5 this time?

The potential to expand on answers to these questions is limitless. We find that scaling questions not only make vague concepts more concrete but also direct the client's attention to the significant people in his or her life. The utility of scaling

questions is immeasurable because clients of all intellectual abilities and cultural and ethnic backgrounds are able to make sense of this tool. We have even used it with a five-and-a-half-year-old to deal with his temper problem.

Relapses and Setbacks

Problems and solutions often occur simultaneously. Serious, long-standing problems seem to take the path of “two steps forward, one step back” or a “good days and bad days” pattern on the way to a lifelong solution. Like most compulsive behaviors, it is difficult to predict what course of recovery an individual will take at the outset of treatment. It makes sense to view problematic gambling as similar to other problems of living. Therefore, solution-building processes must account for the inevitability of “two steps forward, one step back” in the recovery process. Therapists must prepare for these setbacks and not see them as failures. Since relapses are a fact of life, we take a pragmatic stance and suggest a five-step approach to build ways to minimize the negative fallout from such setbacks. The natural temptation is to ask why again? or why this time? — for which most people have no answer. It is best not to press the “why” question since it naturally leads to a defensive posture and language.

A Five-Step Model of Relapse Management

Step 1 - Positive attitude

It is understandable that clients, their families and friends may feel disappointed and frustrated or betrayed by setbacks or relapses. It is easy to fall into blaming, anger, guilt and remorse, and thus, become discouraged enough to say, “To hell with it all!” and give up. During such times, it is particularly useful for therapists to be hopeful and positive with the client and direct attention to any period of successful control over the impulse and the temptation to slide back into gambling. Therapists should emphasize how the client stayed on course for awhile toward the goal of a gambling-free life. Sometimes, this successful exception has lasted for months, even years. We should remind the client and family of the exception and find out the details of how she or he managed to stay gambling-free during that period.

Step 2 Control

Find out what internal or external cues the client responded to when he or she stopped gambling, or walked out of the casino, or made sure to drive right past the gas station that sells lottery tickets. Frequently clients report that the decision to stop gambling was not their own, but that they simply ran out of money, thus denying that they have self-control over the behavior. It is useful to accept this view, but then gently lean forward with a curious expression, and ask, “I can see

that you ran out of money and that was certainly a good time to stop. But tell me, how come you did not borrow money or promise the house to get more money to continue to gamble? You know that there are people who would do anything to get money, including selling their grandmother?" Implied in this curiosity is the message that it was the client who walked out or stopped the negative behavior and not just in response to the circumstances.

By finding out about the minute details of the client's self-control, whether it was thinking about the children's need for shoes or the threat of facing an angry spouse, the therapist implies that the client had control when the money ran out. This same control can be expanded to other situations related to gambling.

Step 3 - Options

The next step is to find out what the client actually did after exerting the self-control to walk away from the casino, drive the long way around to avoid the lottery counter, or turn off the TV when the commercial for a big jackpot came on. Often, a client reports going outdoors and shooting some baskets with his or her children, going directly home and spending time with the children, cutting the grass, shovelling the sidewalk or helping around the house. Obviously these solutions are what the client needs to repeat often once he or she recognizes the pattern of how the temptation to gamble slowly turns into actual behavior. Ways to divert attention to other activities that make the client feel productive and competent become a habitual activity with repetition over time.

Step 4 - Differences

"What was different about this relapse compared to the last one?" The typical language of relapse implies not only that it is constant but also that each relapse or setback is the same. We find that each setback is slightly different; each time what the client does is slightly different from other times. Finding out the details of each setback may reveal that the client is making slow progress toward his or her treatment goal or that the problem is becoming worse. Most of all we find that the details of differences between setbacks are something the client has control over. The client can learn to increase these instances, and thus, gain a sense of mastery over his or her own behavior.

Step 5 - Lessons

"What have you learned about your problematic gambling from this setback?" This question and other similar ones indicate to the client that each event in life offers us a chance to learn and improve our lives; thus, taking advantage of setbacks as an opportunity to learn. Detailed discussion of how the client will incorporate this learning into daily life is useful to make the experience more concrete and practical.

Research and Evaluation of SFBT

Because SFBT was developed inductively in a clinical setting (de Shazer, 1985; Berg, 1994; DeJong & Berg, 1998, 2001) rigorous research that shows its effectiveness is only starting to come forth. Many informal studies have been conducted worldwide in a variety of settings. However, rigorous studies with pre- and post-measurements using controlled and experimental populations are difficult to develop and are just beginning to emerge. Recently, Gingerich and Eisengart (2000) reviewed the research literature on SFBT from the last 25 years as it was being refined as a viable treatment model. An on-line review of SFBT (Macdonald, 2000) is available at http://www.enabling.org/ia/sft/evs.htm.

What is particularly encouraging about the emerging research is the assessment that SFBT is a time-sensitive, cost-effective and highly collaborative approach, with similar or better outcomes, including fewer sessions, than traditional approaches. Further studies are needed to assess the effectiveness of the SFBT approach with different client populations and several such research projects are currently underway in many corners of the world.

Conclusion

We have presented a brief examination of the SBFT approach with problem gamblers and hope that this provides additional tools for clinicians and clients faced with difficult and complex situations. At a minimum, we hope this article sparks an interest in trying some of the techniques presented here. If nothing else, we suggest therapists use scaling questions as the beginning step. Then therapists may want to add exception questions and watch how clients' faces light up. We find that clients' responses to the many suggested questions are the most convincing argument for adopting this model. These small differences are the reasons for our endeavors.

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